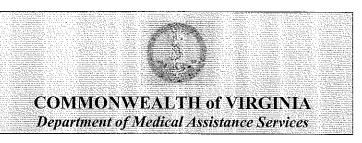
## VIRGINIA MEDICAID REQUEST FOR SERVICE AUTHORIZATION FOR A ATYPICAL ANTIPSYCHOTIC IN CHILDREN LESS THAN 6 YEARS



Requests for service authorization (SA) must include patient name, Medicaid ID#, and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. SUBMISSION OF DOCUMENTATION DOES NOT GUARANTEE COVERAGE BY THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES AND FINAL COVERAGE DECISIONS MAY BE AFFECTED BY SPECIFIC MEDICAID LIMITATIONS.

The completed form may be FAXED TO 800-932-6651. Requests may be phoned to 800-932-6648.

Requests may be mailed to: Magellan Medicaid Administration / 4300 Cox Road / Glen Allen, VA 23060 / ATTN: MAP

Atypical Antipsychotic medications for individuals over 6 years of age do not require authorization.

All questions must be answered or the request will be denied

PATIENT INFORMATION	
Patient's Name:	Patient's Medicaid ID#: (12 digits)
Patient's Date of Birth:	Patient's weight in kilograms:
Are you a child/adolescent psychiatrist; pediatric neurologist; developmental/behavioral pediatrician or a pediatric neurologist?	
Has this Child had a psychiatric consultation or assessment? Yes No If Yes Date of consult:	
Indicate X for all diagnoses being treated:	Organic Psychiatric Conditions Yes No
2) Schizophrenic Disorders Yes No 3	Affective Psychoses (bipolar disorders) Yes No
4) Psychoses Yes No 5	Autism Spectrum Disorders Yes No
6) Tourette's Yes No 7	Reactive Adjustment Disorders Yes No
Or list other diagnoses that apply here	
PATIENTS CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION	
Name of program:	Enrolled in program on:
List pharmaceutical agents attempted and outcome:	
1.	A Section Control of the Control of
2.	
If this request is denied or if more information is required; please list a phone number where you can be reached for a peer to peer consultation with the programs Board Certified Pediatric psychiatrist	
peer consultation with the programs Board Certified Fediatric psychiatrist	
PHYSICIAN INFORMATION	
Physician's Name (print):	Today's Date:
Physician's Signature:	Authorization begin date:
Physician's DEA#:	Phone #: ( )
Physician's National Provider ID#:	Fax #: ( )
PLEASE INCLUDE ALL REQUESTED INFORMATION	
INCOMPLETE FORMS WILL DELAY THE SERVICE AUTHORIZATION PROCESS	

FAX TO 800-932-6651 SERVICE AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE